

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G390 5/29/67 DC

08699

CERTIFICATE OF DEATH

08698

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels (rural)		c. LENGTH OF STAY IN 1b 5 1/2 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		d. STREET ADDRESS Rio Vista Cove Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes Geneva Berry		4. DATE OF DEATH Month June Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1886
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Peterson		14. MOTHER'S MAIDEN NAME Josephine Anna Wisniewski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-09-0741	
17. INFORMANT Mrs. C. B. Greene, Rio Vista,		Address St. Michaels, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) conception - severe 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cardiac DUE TO (c) embolus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) advanced senile changes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 6-21 , 19 67 , that (I) (we) last saw the deceased alive on 6-20 19 67 , and that death occurred at 2 A M, from causes and on the date stated above.		22a. SIGNATURE Guym Reese	
22b. PHYSICIAN'S NAME (Type) Guym Reese		22c. DATE SIGNED 6-23-67	
22d. ADDRESS St. Michaels Md		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/23/1967	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Easton, Md.	
24. FUNERAL DIRECTOR MURICE E. NEUNAM & SON, Easton, Md.		25a. REC'D BY REGISTRAR JUN 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08700

CERTIFICATE OF DEATH

08699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Agnes</u> Middle <u>Catherine</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/14/1893</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Minn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Clausen</u>				14. MOTHER'S MAIDEN NAME <u>Christine Neilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. A. L. Bradley, East New Market</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera with septicemia</u> 585X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus; congestive heart failure</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>5</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>5/29/67</u>		20f. (City or town) (County) (State) <u>East New Market Dor Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6-10-67</u> , 19 <u>67</u> , to <u>6-11-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-10-67</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>				M.D. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Edith S. Hurloughy</u>				ADDRESS <u>East New Market, Md.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 14 1967</u>				25b. REGISTRAR'S SIGNATURE			

82282

8-790

Handwritten notes, possibly a list or description of items, including the word "A" and "B" and some numbers.

Handwritten notes, possibly a list or description of items, including the word "C" and "D" and some numbers.

Handwritten notes, possibly a list or description of items, including the word "E" and "F" and some numbers.

Handwritten notes, possibly a list or description of items, including the word "G" and "H" and some numbers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

please send to F. C. C. 8/10/67 PH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08701

Item 238 Film G391 8/21/67 kk

CERTIFICATE OF DEATH

10111

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
c. LENGTH OF STAY IN 1b <u>45 hrs.</u>		d. STREET ADDRESS <u>R.F.D. # 1- Box 277</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>James</u> Last <u>BOY CANNON</u>		4. DATE OF DEATH Month <u>6-</u> Day <u>9-</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1967</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Boys <u>2</u> Hours <u>2</u> Min.	11. IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerome Sample</u>		14. MOTHER'S MAIDEN NAME <u>Dianne Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Infant</u>	
17. INFORMANT <u>Jerome Sample, Federalsburg, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Bleeding, suspected</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anoxic</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-6</u> , 19 <u>67</u> to <u>6-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-6</u> , 19 <u>67</u> , and that death occurred at <u>3:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>William A. Hatfield</u>		22b. DATE SIGNED <u>6/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William A. Hatfield</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rhodesdale Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rhodesdale, Md., RFD</u>	
24. FUNERAL DIRECTOR <u>Frankton Funeral Home Federalsburg Md</u>		25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		25c. REGISTRAR'S SIGNATURE	

• • •

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

210
08700

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>H.</u> Last <u>Copper</u>				4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1929</u>	9. AGE (In years last birthday) yrs <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANNORY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES HAWKINS</u>				14. MOTHER'S MAIDEN NAME <u>ROSIE ELLA WARRICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-5731</u>		17. INFORMANT <u>WILLIAM COPPER - Easton, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SHOCK-</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE GENERALIZED PERITONITIS POST</u> <u>HYSTERECTOMY</u> (c) <u>DUE TO</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>OLD HEALED PULMONARY TUBERCULOSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis S. Welty</u>		EXAMINER'S NAME (Type) <u>LOUIS S. WELTY</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>6-20-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>BURIAL</u>		<u>6-23-67</u>		<u>NEWTOWN</u>		<u>NEWTOWN TALBOT MD</u>	
24. FUNERAL DIRECTOR <u>B. H. DASHIELL - Easton, MD</u>				25. REC'D BY REGISTRAR DATE <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00780

00780

THE DISTRICT OF COLUMBIA

REGISTERED

OFFICE OF THE DISTRICT

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08703

CERTIFICATE OF DEATH

08701

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. STREET ADDRESS <u>BURRILL-CENTREVILLE</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Clifton</u> Last <u>Deaton</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-29-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PHILIP DEATON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BLAINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>155-0766X3</u>	
17. INFORMANT <u>Philip H. DEATON</u>		Address <u>CENTREVILLE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7:35</u> to <u>7:35</u> , that (I) (we) last saw the deceased alive on <u>June 19</u> , and that death occurred at <u>7:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E.C.H. Schmidt</u>		22b. DATE SIGNED <u>6-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS <u>Centreville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BURRILL-CENTREVILLE</u>	23d. LOCATION (City or Town) (County) (State) <u>QUEEN ANNE MD</u>
24. FUNERAL DIRECTOR <u>Harshel General Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2080

2073

2073

2073

2073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

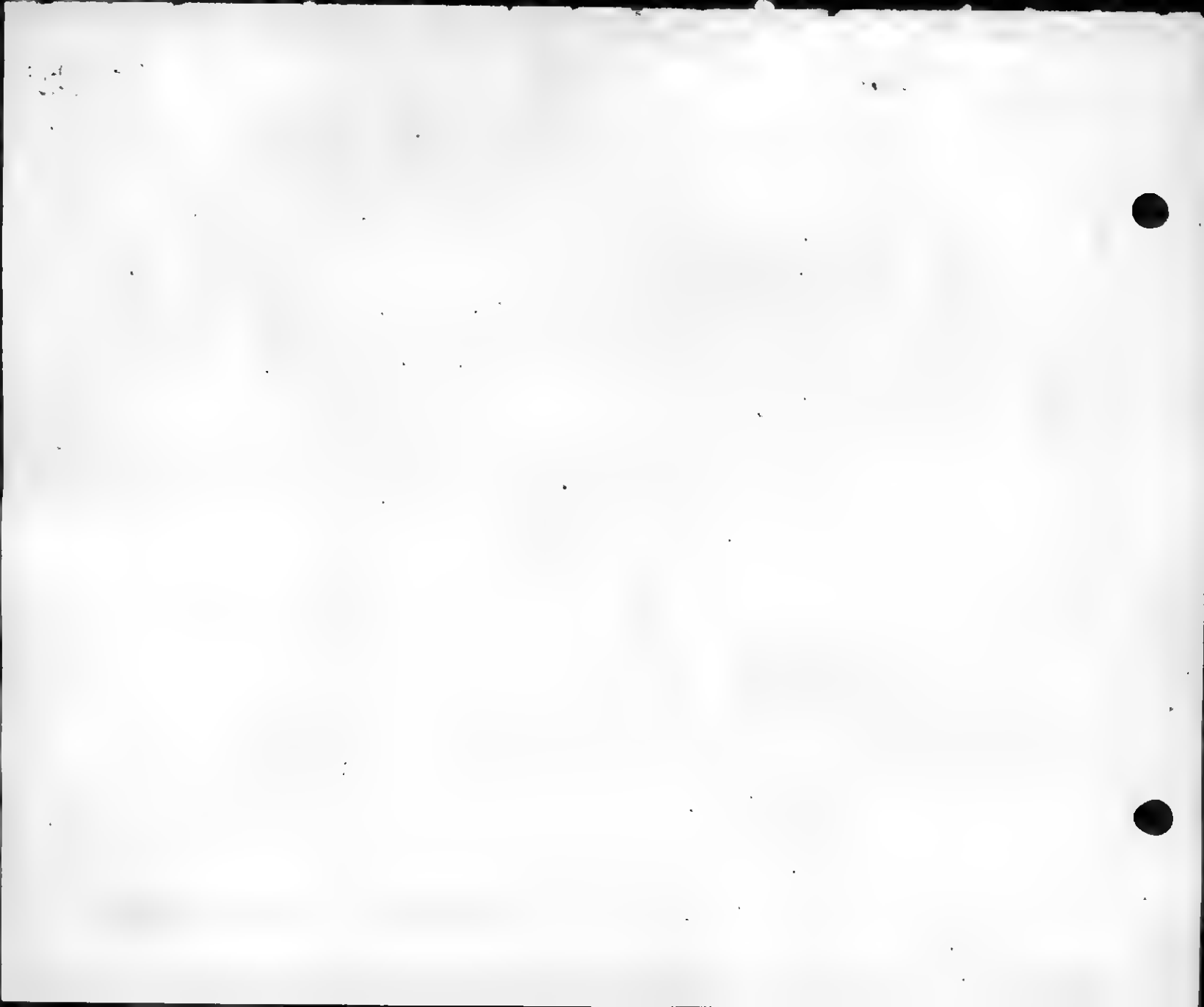
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08704

CERTIFICATE OF DEATH

08703

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 3 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - EASTON	
3. NAME OF DECEASED (Type or print) Hattie Belle Dukes		d. STREET ADDRESS RT 2 - Bx 99A	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 4, 1912
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE LANE		14. MOTHER'S MAIDEN NAME HATTIE DAFFIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-16-8343	
17. INFORMANT WILLIAM H. DUKES, EASTON, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, second I 4201 DUE TO (b) old Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt		22b. DATE SIGNED 6-3-67	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Easton - Maryland	
23a. BURIAL, CREMATION, EMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 5, 1967	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN MEMORIAL PARK	23d. LOCATION (City, town or county) (State) EASTON, MARYLAND
24. FUNERAL DIRECTOR Harrison E. Leonard, St. Michael's, Md.		25a. REC'D BY REGISTRAR DATE JUN 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

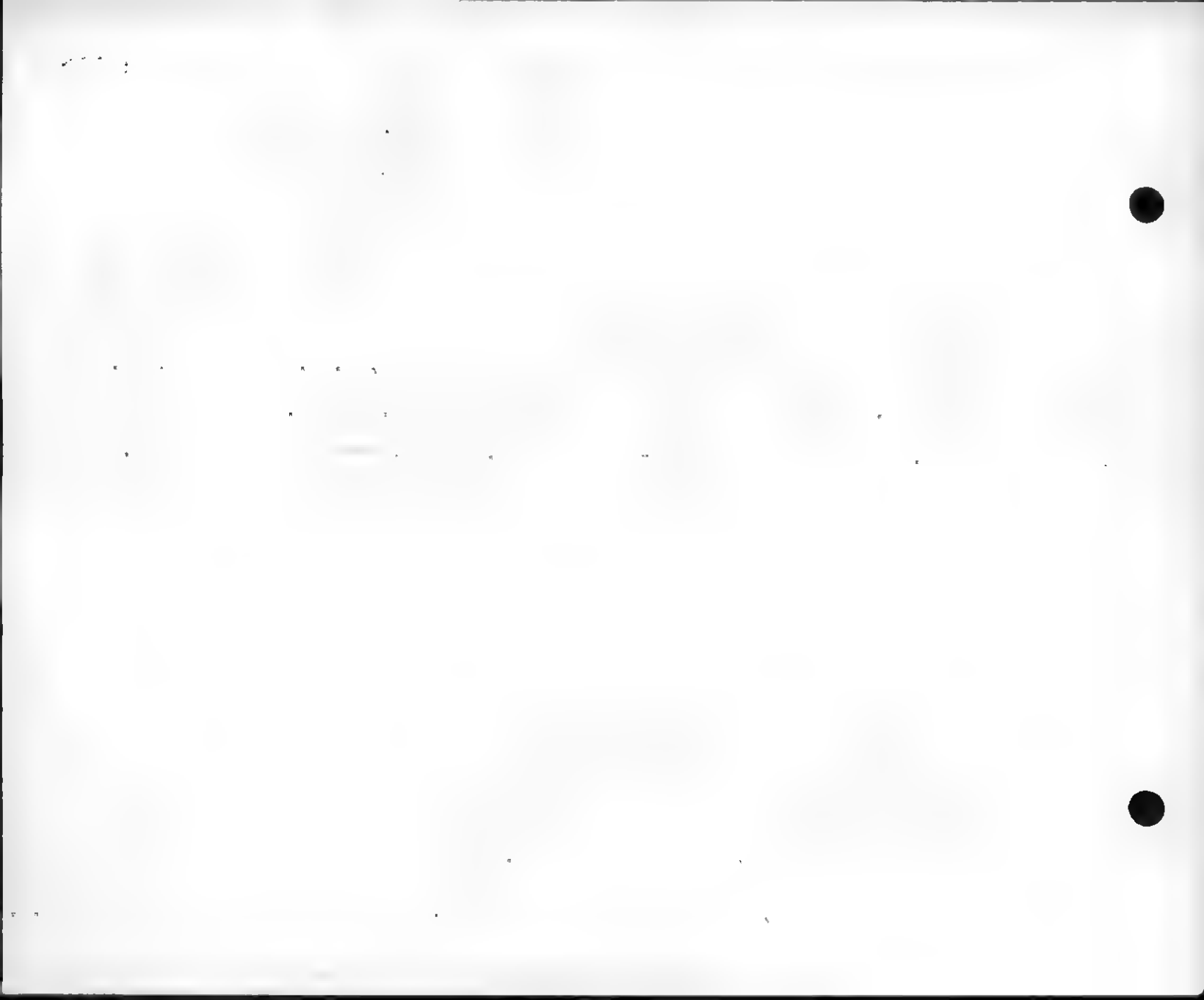
08705

CERTIFICATE OF DEATH

08703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Md. b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN TB 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob Henry Earle		4. DATE OF DEATH June 18 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-04
9. AGE (In years, lost birthday) 63 yrs.		10. UNDER 1 Year <input type="checkbox"/> 1 Year to 24 Months <input type="checkbox"/> 24 Months to 1 Year <input type="checkbox"/> 1 Year to 24 Months <input type="checkbox"/> 24 Months to 1 Year <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State or foreign country) Patterson, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob H. Earle		14. MOTHER'S MAIDEN NAME Carrie L. Sroder.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 706-14-5162	
17. INFORMANT Mrs. Lydia A. Earle,		Address Barclay, Md. 21607	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hodgkins disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 7:06 P.M., from causes and on the date stated above.			
22a. SIGNATURE Robert W. Trever		22b. DATE 6/19/67	
22c. PHYSICIAN'S NAME (Type) Robert W. Trever		22d. ADDRESS M.D. Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June, 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fair Lawn Cemetery.		23d. LOCATION (City or town) (County) (State) Hawthorne N.J.	
24. FUNERAL DIRECTOR Edward F. Holloway		ADDRESS 2711 Millington, N.D.	
25a. REC'D BY REGISTRAR JUN 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

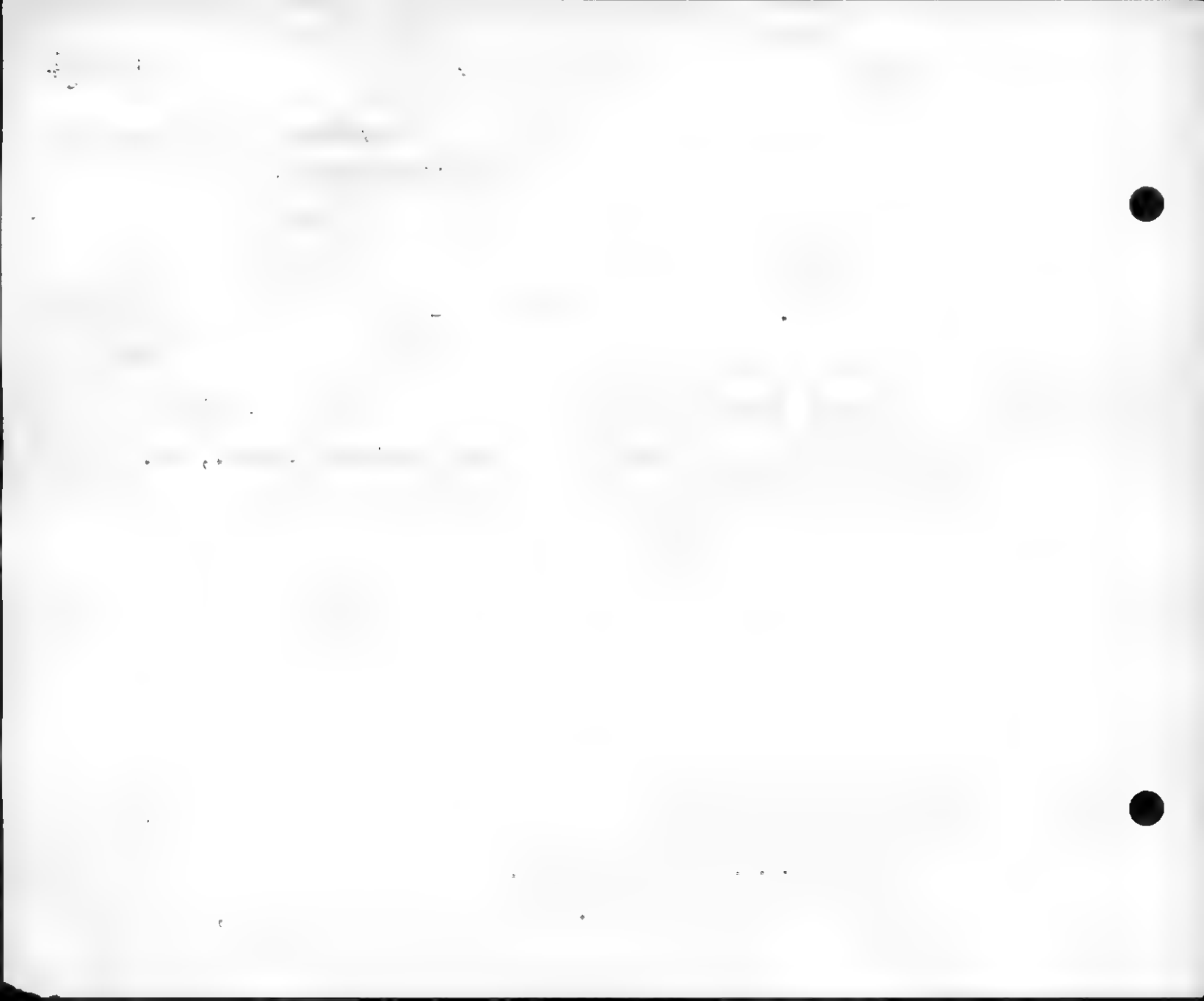
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08706

CERTIFICATE OF DEATH

08704

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Hayd</u> Middle <u>Wesley</u> Last <u>Evans</u>				4 DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-10-1930</u>	9. AGE (In years last birthday) <u>36</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Evans</u>				14 MOTHER'S MAIDEN NAME <u>Lydia Fountain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Helen Daniels Phila., Pa.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1531 Isonia</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma transverse colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (the hospital) attended the deceased from <u>5/14</u> , 19 <u>67</u> , to <u>6/10</u> , 19 <u>67</u> that (I) (the) last saw the deceased alive on <u>6/9</u> , 19 <u>67</u> , and that death occurred at <u>9 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>J.T.B. Ambler</u>				22b. DATE SIGNED <u>6/13/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J.T.B. Ambler</u>	
22d. ADDRESS <u>M.D. Easton, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		23d. LOCATION (City or Town) (County) (State) <u>Marydel, Maryland</u>	
24. FUNERAL DIRECTOR <u>John E. Boula's Greenboro Md</u>				25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08707

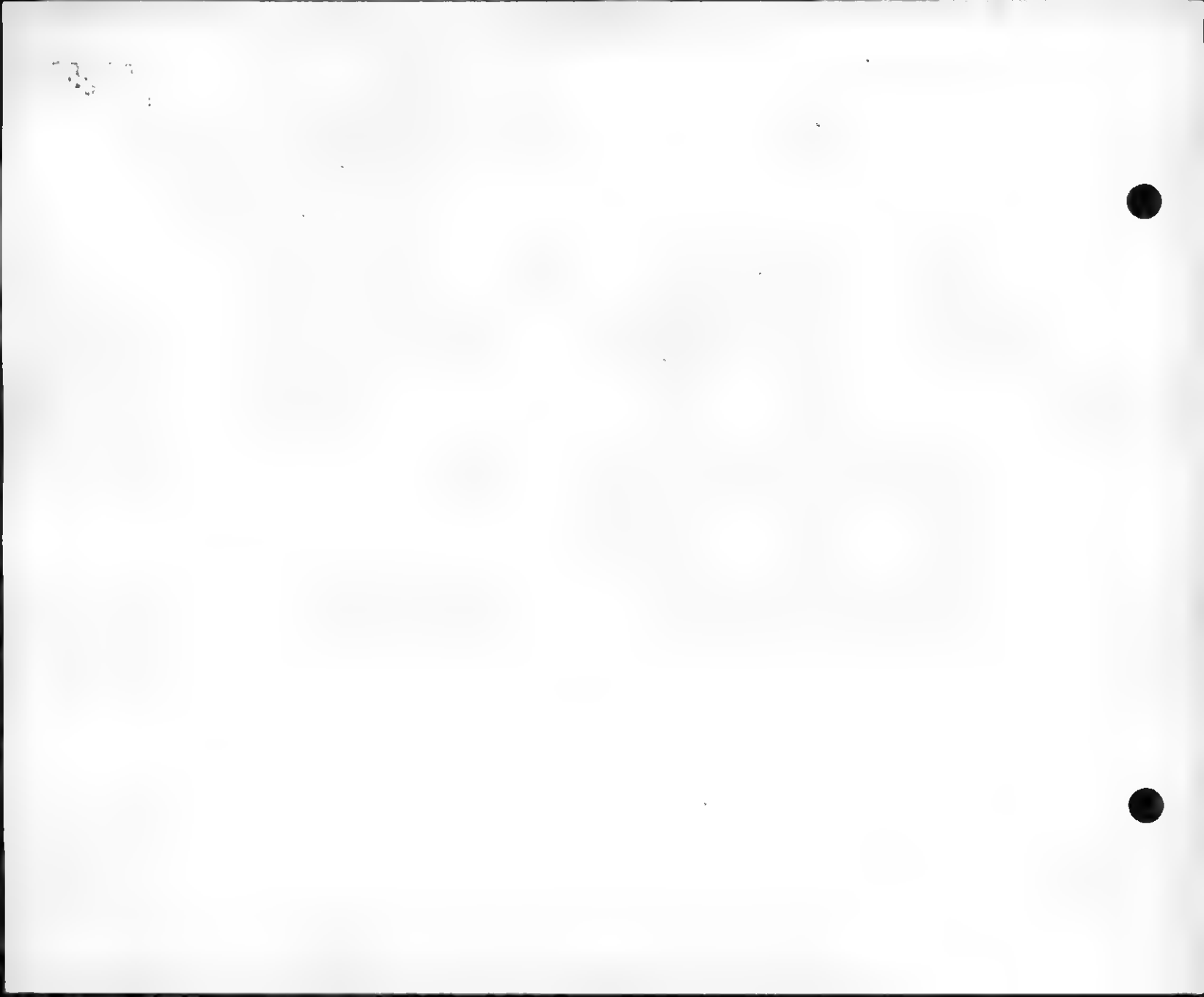
CERTIFICATE OF DEATH

08705

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 835 E. Church St	
3. NAME OF DECEASED (Type or print) First Edward Middle LEE Last Ford		4. DATE OF DEATH Month 6 Day 18 Year 1967	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/1895
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL SALES, RET.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, TALBOT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Ford		14. MOTHER'S MAIDEN NAME ESTELLE PORTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WWI		16. SOCIAL SECURITY NO	
17. INFORMANT MRS ELLA COLLINS EASTON, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of prostate DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt M.D.		22b. DATE SIGNED 19 June 1967	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-21-1967	23c. NAME OF CEMETERY OR CREMATORY Wic. Mem. Park	23d. LOCATION (City or town) (County) (State) Salisbury Wic. Md.
24. FUNERAL DIRECTOR Hill Funeral Home		25. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JUN 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and if any patient, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

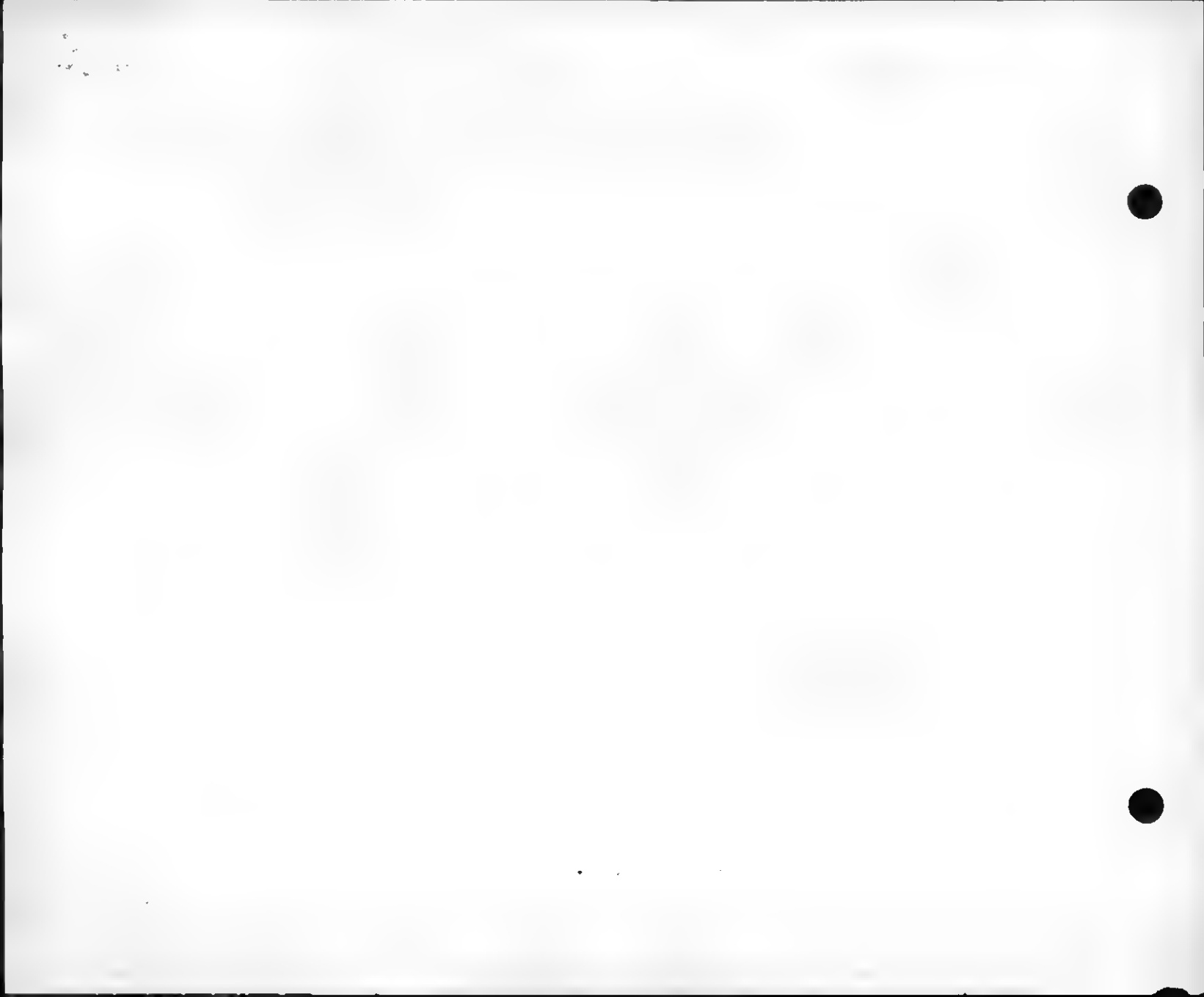
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08708

CERTIFICATE OF DEATH

08706

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN TB <u>4 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD. EASTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Gibson</u> Last <u>Gibson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1905</u>		9. AGE (In years last birthday) <u>61</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>MR. KNOX</u>				14. MOTHER'S MAIDEN NAME <u>ELSIE HINES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-8992</u>		17. INFORMANT <u>NELLIE GIBSON</u>		Address <u>EASTON MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>410X</u> IMMEDIATE CAUSE (a) <u>Rheumatic heart disease, inactive,</u> DUE TO <u>with mitral stenosis and regurgitation,</u> (b) <u>aortic stenosis and regurgitation, and</u> (c) <u>congestive heart failure</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>9:45</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RICHARDSON</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD.</u>	
24. FUNERAL DIRECTOR <u>George A. Doherty</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08707

M

08709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN TB <u>2 d</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAEL'S</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Philemon THOMAS Hambleton</u>		4 DATE OF DEATH <u>6 17 1967</u>	
5. SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 10, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	11 BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MD</u>
13 FATHER'S NAME <u>THOMAS B. HAMBLETON</u>		14 MOTHER'S M maiden NAME <u>LILLIAN BURROWS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or rank and dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-10-5610</u>	
17 INFORMANT <u>MRS. MAYSIE S. HAMBLETON, BOZMAN, MD</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO <u>atherosclerotic coronary art d</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVA. BETWEEN ONSET AND DEATH <u>Two</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cor pulmonale, Diabetes M.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>6-17-67</u> that (I) (we) last saw the deceased alive on <u>6-17-1967</u> and that death occurred at <u>8:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Harrison E. Leonard</u>		22b. DATE SIGNED <u>6-20-67</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Dr. Michael M.D.</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOZMAN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BOZMAN, MARYLAND</u>
24. FUNERAL DIRECTOR <u>Harrison E. Leonard</u>		25a. REC'D BY REGISTRAR <u>S. Michael M.D.</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08710

CERTIFICATE OF DEATH

08708

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>-</u>			
3 NAME OF DECEASED (Type or print) First <u>EUNICE</u> Middle <u>SMITH</u> Last <u>Holland</u>				4 DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>			
5 SEX <u>FEMALE</u>		6 COLOR OR RACE <u>N</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>MAR 4, 1915</u>	
9 AGE (in years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11 BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MD</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>CHARLES SMITH</u>				14 MOTHER'S MAIDEN NAME <u>SARAH JACKSON</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>220-01-7121</u>		17. INFORMANT <u>Melvin Holland, St. Michaels Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary occlusion</u> DUE TO <u>Coronary occlusion</u> (b) <u>Coronary occlusion</u> (c) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>9th</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>11 June 67</u>		22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>	
22d. ADDRESS <u>Easton, Maryland</u>							
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE THEREOF <u>JUN 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>THOMAS MEMORIAL</u>		23d. LOCAT ON (City or Town) (County) (State) <u>ST. MICHAELS MD.</u>	
24. FUNERAL DIRECTOR <u>Harrison & Leonard St. Michaels Md.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

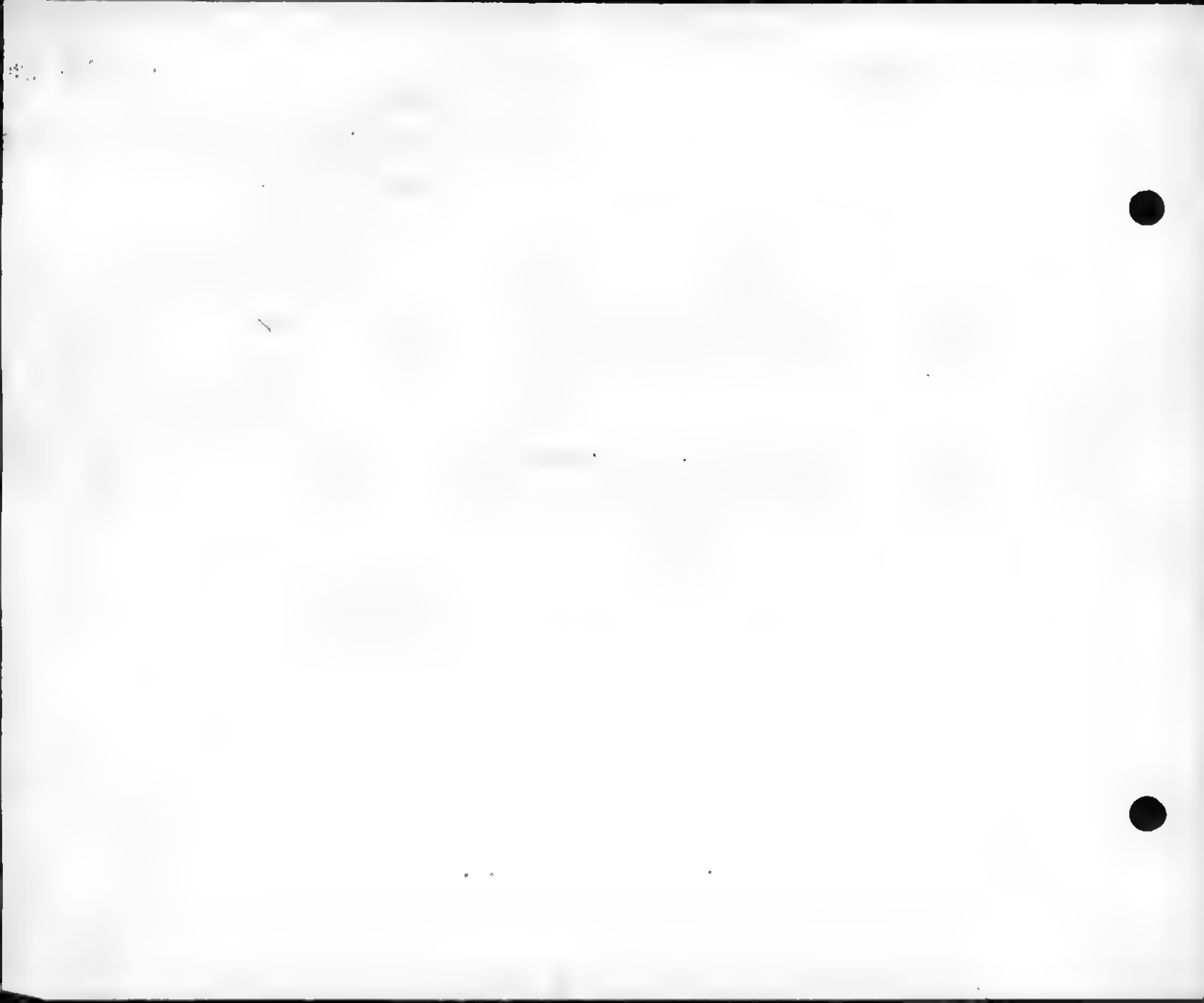
08711

08709

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. STREET ADDRESS <u>LENTAEVILLE</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Jacobs</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1890</u>
9. AGE (In years lost birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH JACOBS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>217-308723</u>	
17. INFORMANT <u>Josephine JACOBS</u>		Address <u>CHESTER PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 142X DUE TO (b) <u>Hypertensive cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6-5-67</u> <u>Uncertain</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>6/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BURASVILLE</u>	23d. LOCATION (City or Town) (County) (State) <u>BURASVILLE QUEEN ANNE MD</u>
24. FUNERAL DIRECTOR <u>George H. Parkhill Easton MD</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08712

CERTIFICATE OF DEATH

08710

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>8 DA.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>116 HANSON ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen Kellum</u>		4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/1911</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red.) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MD.</u>		12. CIT. ZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JAMES THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-485</u>	
17. INFORMANT <u>WILLIAM KELLUM</u>		Address <u>EASTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>lym.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/15/67</u> , to <u>6/27/67</u> , that (I) (we) last saw the deceased alive on <u>6/27/67</u> , and that death occurred at <u>1 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert M. McDonald</u>		22b. DATE SIGNED <u>6/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert McDonald</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton-TALBOT MD</u>
24. FUNERAL DIRECTOR <u>Barbara Dushell Davis</u>		25. REC'D BY REGISTRAR <u>JUL 5 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



08711

FOR STATE
HEALTH DEPT.

08713

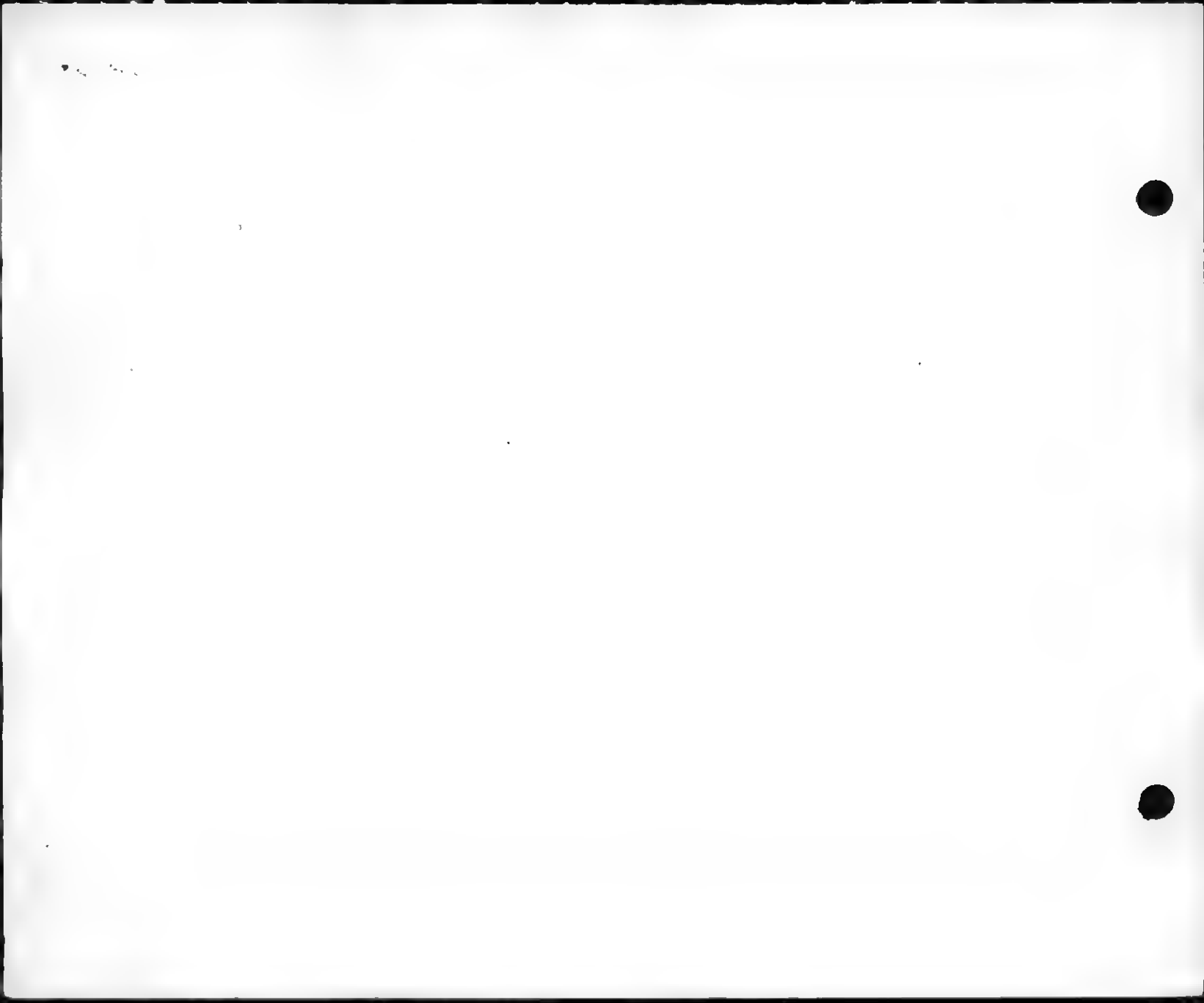
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

349aw.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

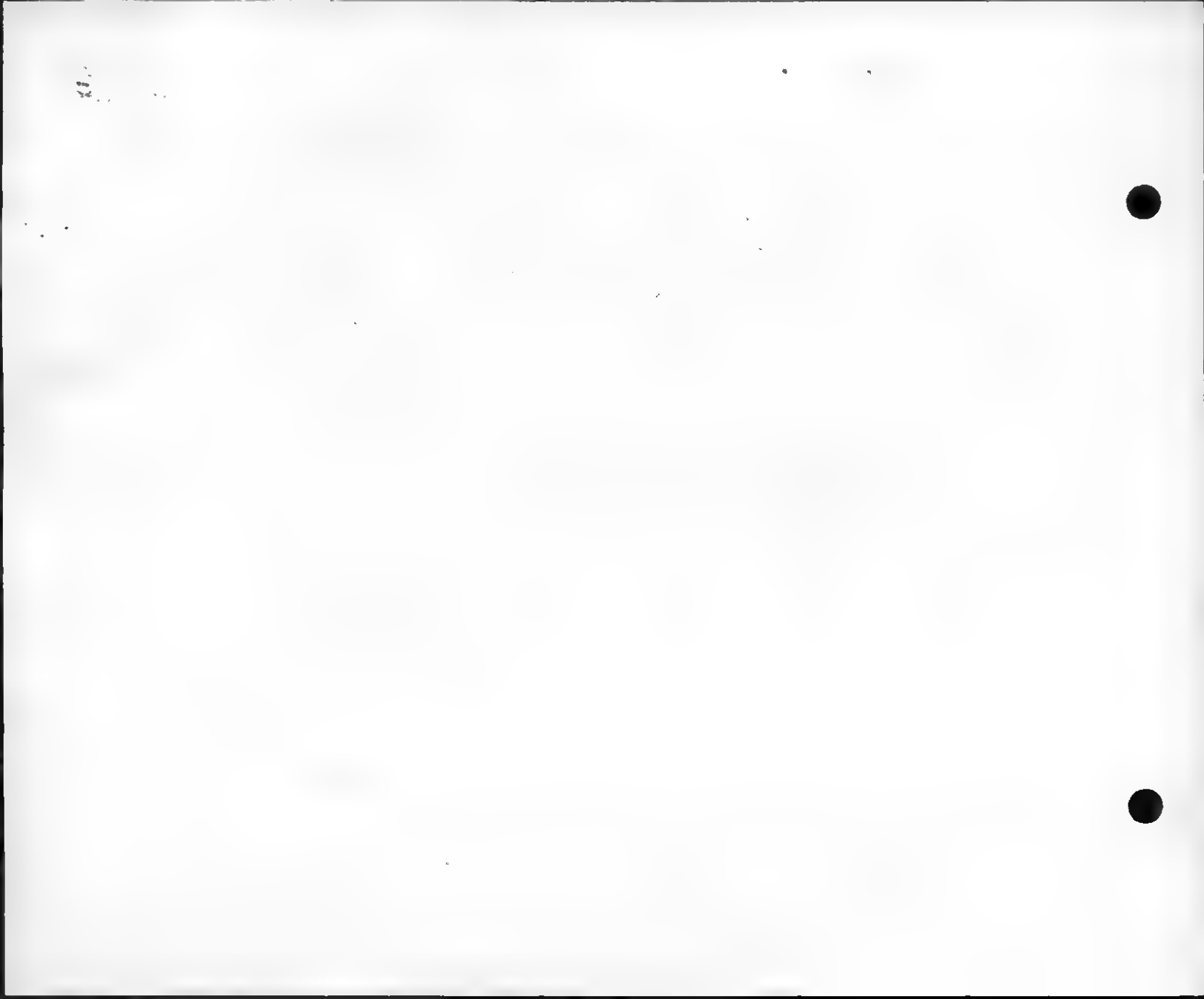
1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a STATE <u>MD.</u> b COUNTY <u>TALBOT</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>DOA.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - EASTON</u>	
f STREET ADDRESS		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mrs. Hazel Lawrence</u>		4 DATE OF DEATH Month <u>6.</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-2-31</u>
9 AGE (In years last birthday) <u>36</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> F UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>NORMAN JOHN</u>		14 MOTHER'S MAIDEN NAME <u>MABLE WILSON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>JAMES LAWRENCE</u>		Address <u>OXFORD MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute alcoholism</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis J. Welty</u> M.D.		22. DATE SIGNED <u>7-1-67</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>7-4-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>TRAPPE</u>	23d LOCATION (City or town) (County) (State) <u>TRAPPE TALBOT MD.</u>
24 FUNERAL DIRECTOR <u>DASHIELL FUNERAL</u>		25a REC'D BY REGISTRAR <u>HARVEY</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



08712

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - St. Michaels</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stanton Ray Lilly</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1921</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. Scientist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Athens, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shelby Gould Lilly</u>		14. MOTHER'S MAIDEN NAME <u>Effie Grimm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>235-26-1759</u>	
17. INFORMANT <u>Mrs. Charles Smith, Chesapeake, Virginia</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>< 24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Harrison E. Leonard, St. Michaels Md.</u>		22d. ADDRESS <u>EASTON, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Athens Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Athens, West Virginia</u>
24. FUNERAL DIRECTOR <u>Harrison E. Leonard, St. Michaels Md.</u>		25. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

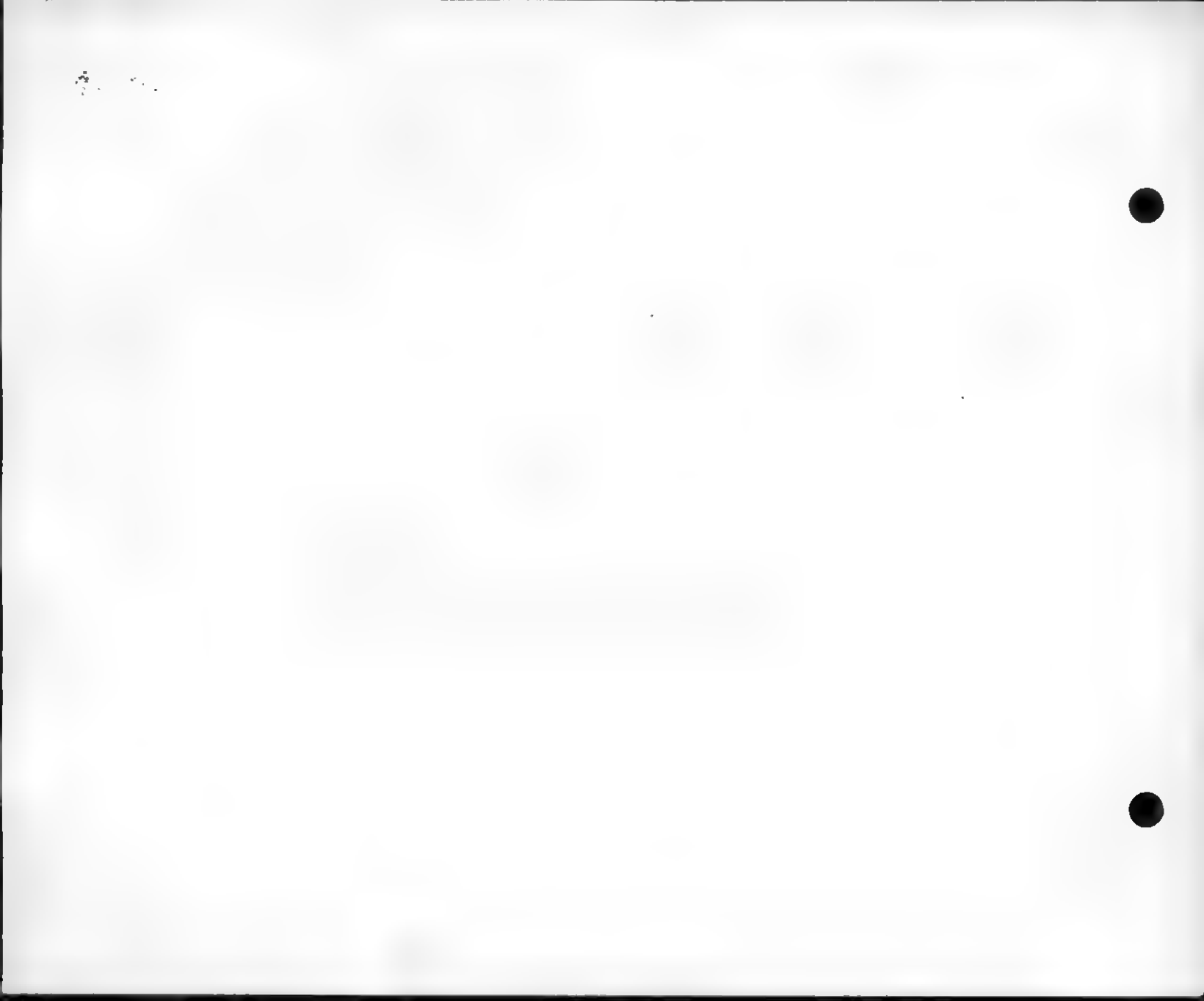
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08715

CERTIFICATE OF DEATH

08713

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residents before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN TB <u>31 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>ROYAL OAK</u>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>MACK</u> Last <u>KEY</u>				4. DATE OF DEATH Month <u>6</u> - Day <u>14</u> - Year <u>1967</u>			
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>NEGRO</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4-1884</u>	
9 AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>TALBOT MD.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>THEODORE MAGKEY</u>				14 MOTHER'S MAIDEN NAME <u>REBECCA SKINNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>230-38-9968A</u>		17 INFORMANT <u>HARRIET ROMERO</u> Address <u>NEW YORK</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>atherosclerotic coronary a.d.</u> DUE TO (c) <u>atherosclerosis - generalized</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atherosclerosis - generalized</u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> , 19 <u>67</u> , to <u>6-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-14</u> , 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Wm. M. Breen</u>				22b. DATE SIGNED <u>6-14-67</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>St. Michael's Med</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RICHARDSON</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>	
24. FUNERAL DIRECTOR <u>B. C. Dushell</u>				25. RECEIVED BY REGISTER DATE <u>JUN 19 1967</u> REGISTER'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



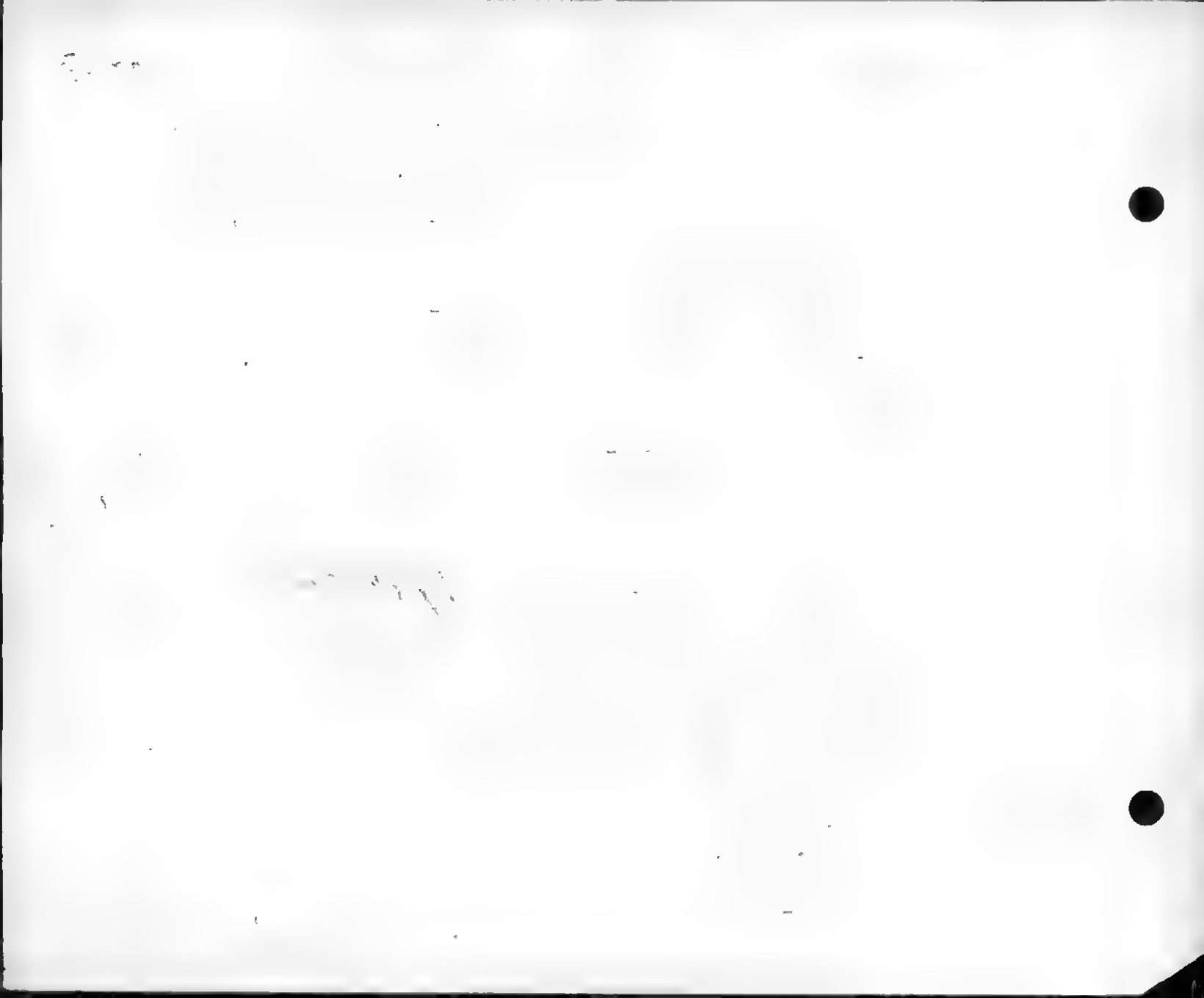
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08716

CERTIFICATE OF DEATH

08714

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN TB 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS RT# 2 Box# 232, Easton, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Leroy Madison				4 DATE OF DEATH Month June Day 7 Year 1967			
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-12-1913		9 AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (County & State, or foreign country) Connellsville, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown by Widow				14. MOTHER'S MAIDEN NAME Unknown by widow			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO 171-16-3127		17 INFORMANT Grace Madison (widow) Address same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBARACANOID HEMORRHAGE DUE TO (HYPERTENSION) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) MALIGNANT HYPERTENSION DUE TO (c) YRS.						INTERVAL BETWEEN ONSET AND DEATH 11 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUGENAL ULCER DISEASE						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-28 , 19 67 , to 6-7 , 19 67 , that (I) (we) last saw the deceased alive on June 7 , 19 67 , and that death occurred at A M, from causes and on the date stated above.							
22a SIGNATURE R. Tyson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 6-7-67	
22c PHYSICIAN'S NAME (Type) RICHARD TYSON				22d. ADDRESS Easton Md 21601			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6-10-1967		23c NAME OF CEMETERY OR CREMATORY Trappe Cemetery		23d LOCATION (City or town) (County) (State) Trappe, Talbot Md	
24. FUNERAL DIRECTOR Charles W. Hill - Denton				25a REC'D BY REGISTRAR DATE JUN 12 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

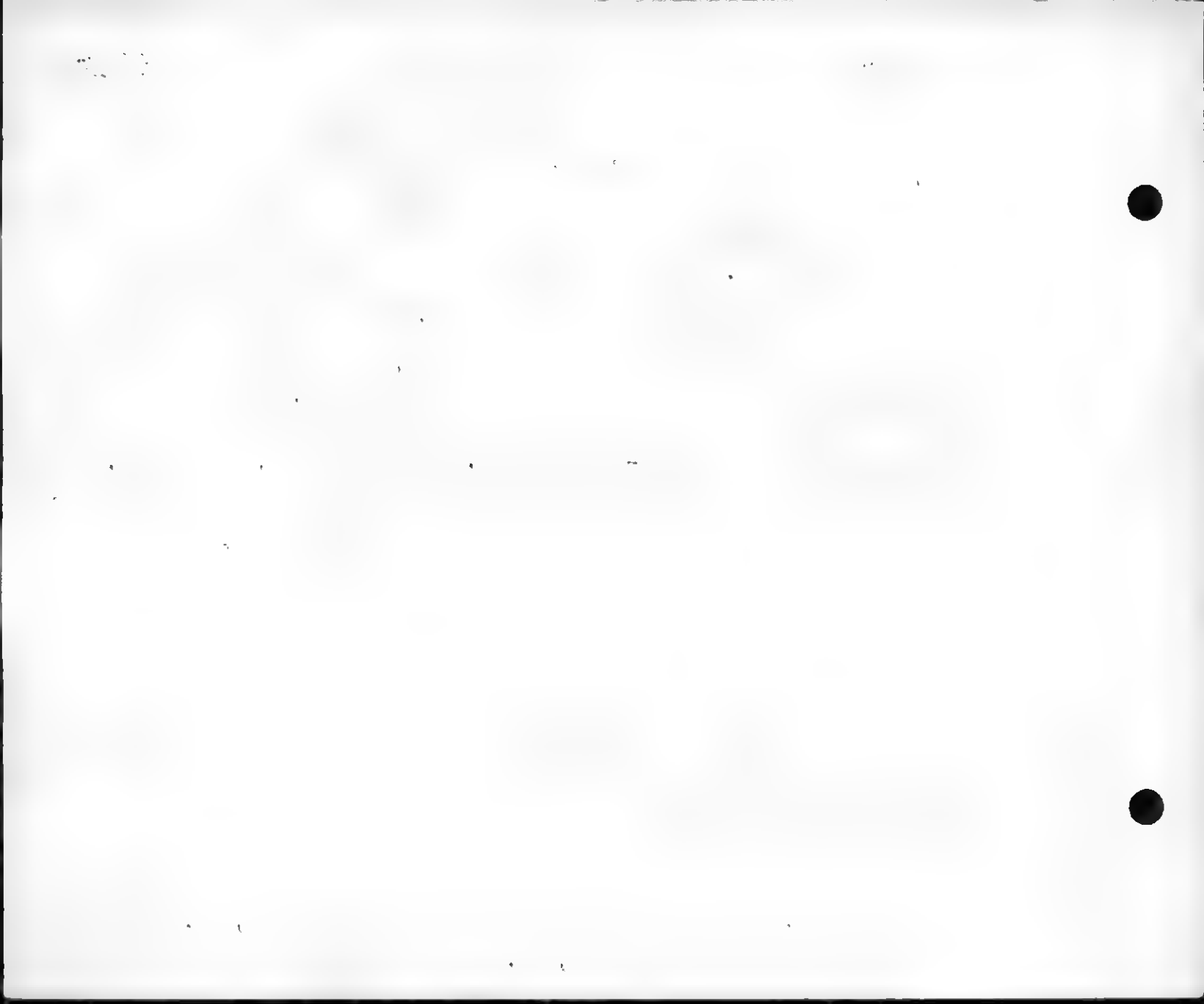
08717

CERTIFICATE OF DEATH

08715

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels (Rural)		c. LENGTH OF STAY IN lb 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara K. Mulder		4. DATE OF DEATH Month June Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1878
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Bryan		14. MOTHER'S MAIDEN NAME Elizabeth Dolby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-48-5492	
17. INFORMANT Mrs. Nellie Gambrill, Easton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1967 to 16 June 1967 that (I) (we) last saw the deceased alive on 15 June 1967 and that death occurred at 8:20 P. from causes and on the date stated above.			
22a. SIGNATURE Arthur W. Smith		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Landing Neck		23d. LOCATION (City or town) (County) (State) Easton, Md.	
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		25c. DATE JUN 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert page 1 and 2 in the envelope and return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08716

VR AIS (4)
25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08719

CERTIFICATE OF DEATH

08719

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN b. <u>3 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John TENERELL PAYNE</u>			4. DATE OF DEATH Month <u>6</u> - Day <u>13</u> - Year <u>1967</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JANUARY 25, 1876</u>		9. AGE (In years last birthday) <u>91</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RATE SPECIALIST</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Interstate Commerce Commission</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dadeville, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Hensley Payne</u>			14. MOTHER'S MAIDEN NAME <u>SARAH FRANCES JENNING</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-8698</u>		17. INFORMANT <u>Daughter</u> Address <u>Mrs. William L. Franklin, Centreville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____					INTERVAL BETWEEN ONSET AND DEATH <u>< 10 min.</u> <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome due to cerebral arteriosclerosis. Fracture left humerus.</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Unknown to me</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>6/10</u>, 19<u>67</u>, to <u>6/13</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>6/13</u>, 19<u>67</u>, and that death occurred at <u>11:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>			22b. DATE SIGNED <u>6-14-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		
22d. ADDRESS <u>Easton, Maryland</u>			22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR <u>James H. Barton Jr., Barton Bros., Centreville, Md. 21617</u>					
25a. REC'D BY REGISTRAR <u>June 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08720

CERTIFICATE OF DEATH

08718

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MD. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS	
c. LENGTH OF STAY IN 13da.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Elmina Kileout		4 DATE OF DEATH 6 21 19 67	
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) TALBOT MD.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM PURNELL		14. MOTHER'S MAIDEN NAME MOLLIE PINTNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO ?	
17. INFORMANT LEONA THOMAS - ST. MICHAELS		Address MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Artery Sclerosis DUE TO (b) 1 year DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8 June 1967 to 21 June 1967 , that (I) (we) last saw the deceased alive on 21 June 1967 , and that death occurred at 7:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE R. Lane Wroth		22b. DATE SIGNED 6-22-67	
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth		22d. ADDRESS M.D. St. Michaels, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-67	
23c. NAME OF CEMETERY OR CREMATORY TAPPE		23d. LOCATION (City or Town) (County) (State) TALBOT MD.	
24. FUNERAL DIRECTOR Dashells Funeral Home		25a. REC'D BY REGISTRAR JUN 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08721

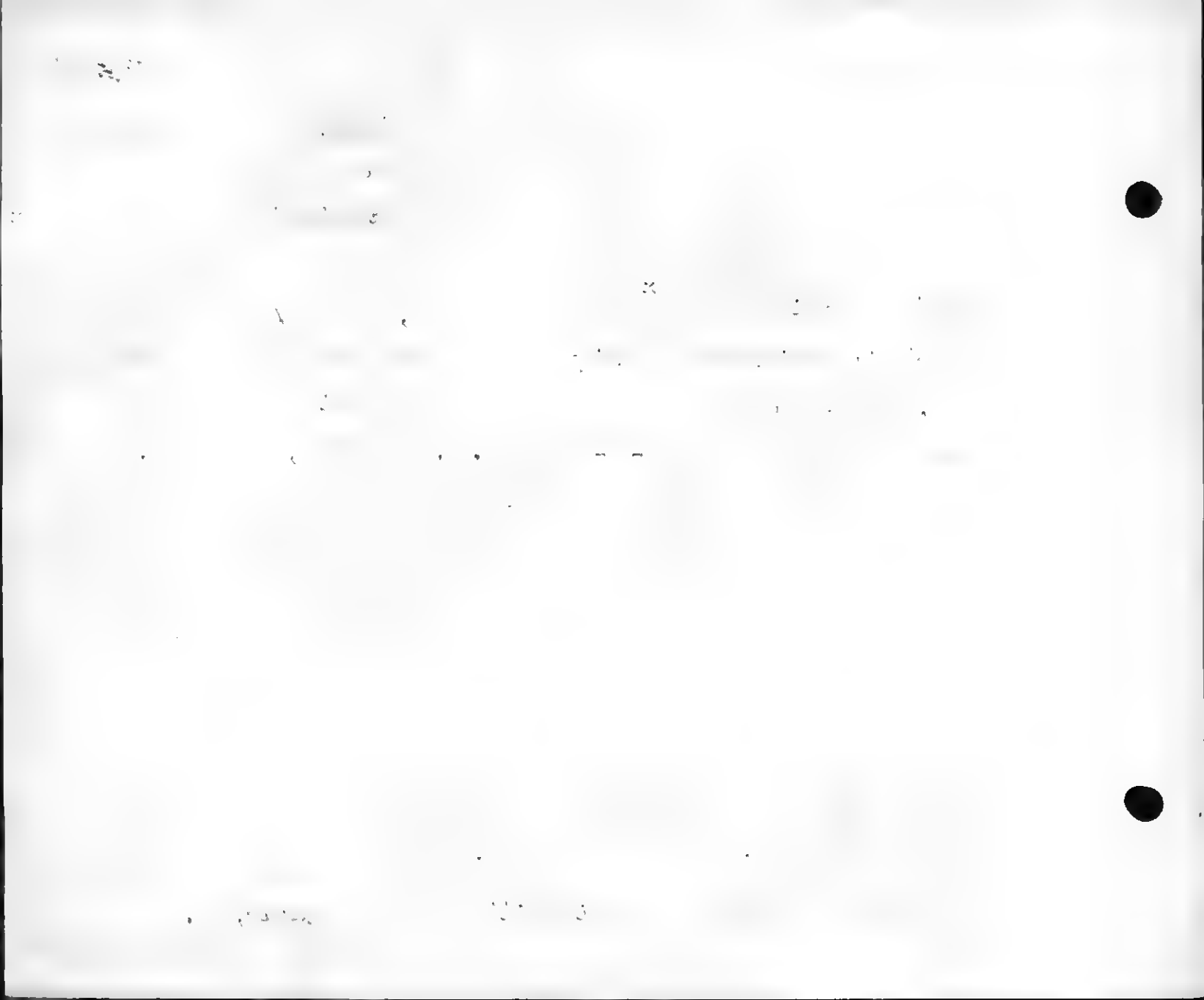
CERTIFICATE OF DEATH

08719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and they must be filed within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>23 hr. 35 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u>			d. STREET ADDRESS <u>20 Park Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>HARRISON</u> Last <u>ROSS, JR.</u>			4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1906</u>		9. AGE (In years last birthday) yrs <u>61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, ever practiced) <u>Machinist (Maintenance)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>	
13. FATHER'S NAME <u>J. Haddaway Ross</u>			14. MOTHER'S MAIDEN NAME <u>Emma Mullikin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>217-14-8632</u>	17. INFORMANT Address <u>Mrs. J. Harry Ross, Easton, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> DUE TO (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>Uncertain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>< 24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic obstructive pulmonary emphysema</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>1140p</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Robert W. Trever</u>			22b. DATE SIGNED <u>6/19/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6/22/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>
24. FUNERAL DIRECTOR <u>Maurice E. Deunamason</u>			25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

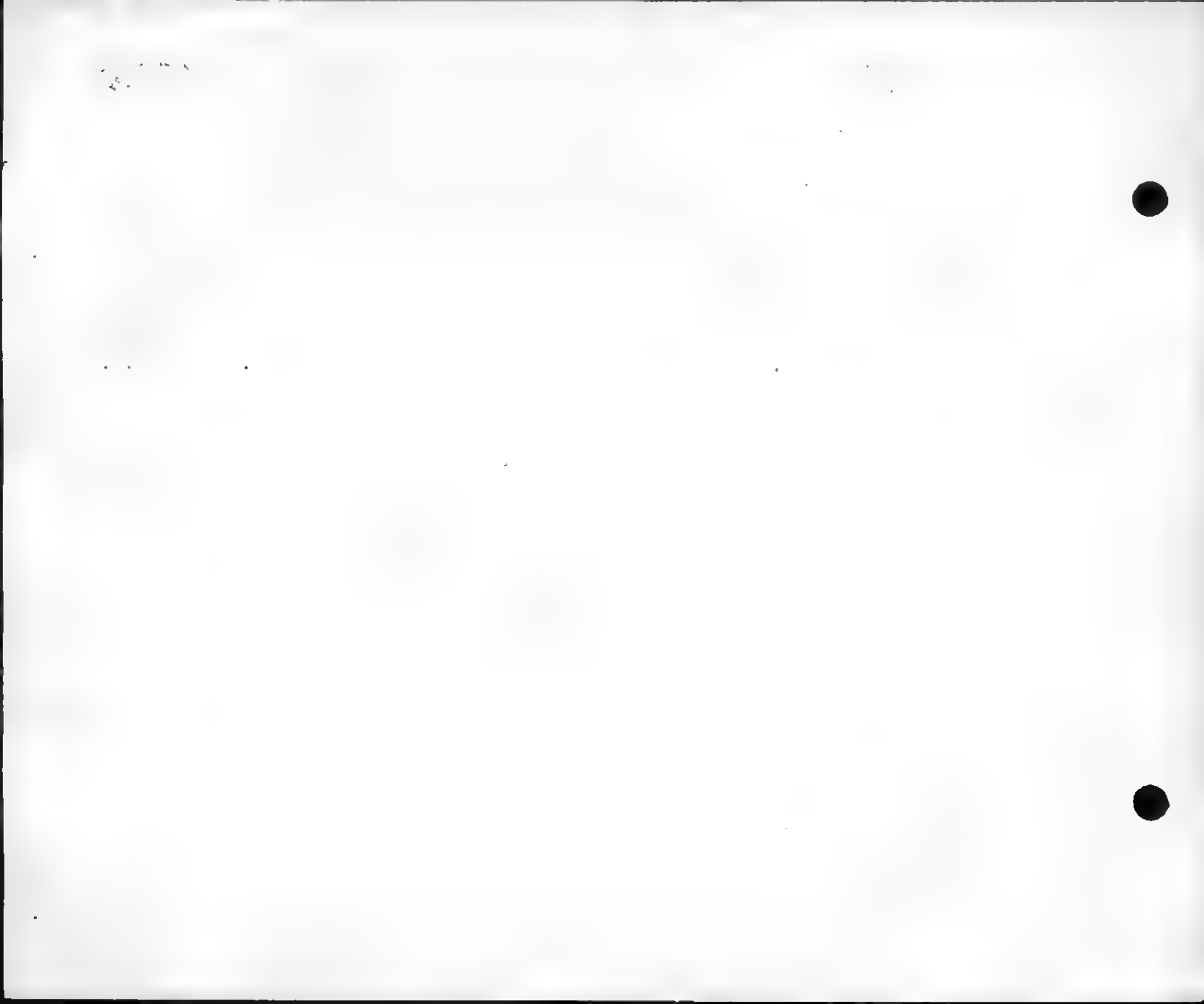
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08722

08720

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY in lb <u>1 hr.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d STREET ADDRESS <u>South Main Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph Clayton Rosser, Sr.</u>				4 DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 18, 1910</u>	9 AGE (In years lost birthday) yrs <u>56</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator and Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning House</u>		11 BIRTHPLACE (State or foreign country) <u>Caroline County, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Rosser</u>				14 MOTHER'S MAIDEN NAME <u>Emma S. Dalious</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>J. Edwin Rosser, Federalburg, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>307x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) <u>chronic alcoholism</u> DUE TO (c) <u>determining trauma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>(-)</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Thorston Harrison</u>		EXAMINER'S NAME (Type) <u>THORSTON HARRISON</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <u>12 June 67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Federalburg, Caroline Md.</u>	
24. FUNERAL DIRECTOR <u>Thorston Harrison</u>				25a. REC'D BY REGISTRAR <u>JUN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

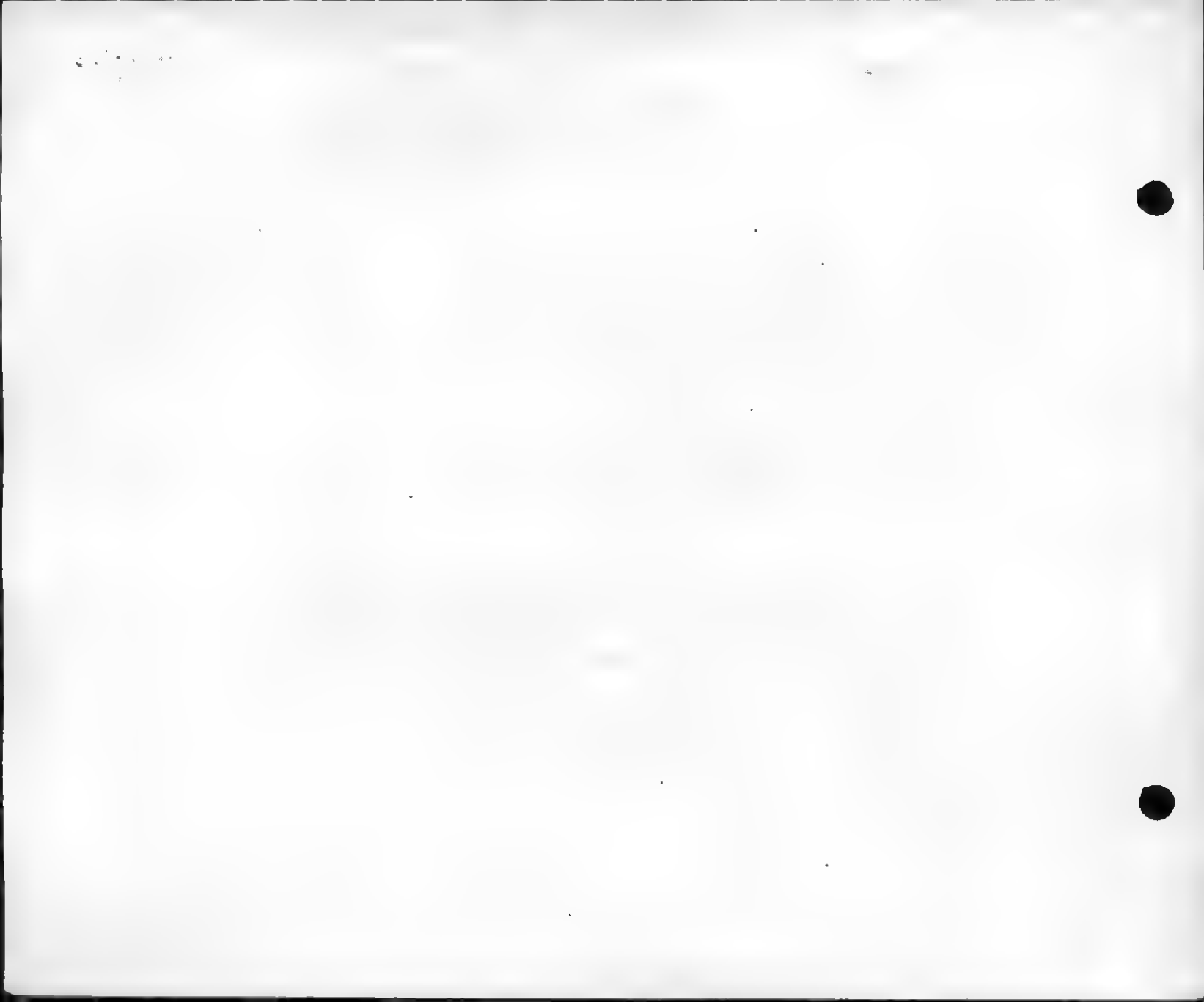
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

087223

08721

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>703 ELWOOD AVE.</u>		d. STREET ADDRESS <u>703 ELWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA AMELIA SQUIRES</u>		4. DATE OF DEATH Month Day Year <u>JUNE 27 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27, 1879</u>
9. AGE (In years last birthday) <u>87 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN E. RICHARD CANN</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA CATTS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-52-8643</u>	
17. INFORMANT <u>MRS ORAN B. HARRISON, EASTON, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6:20</u> , 19 <u>67</u> , to <u>6:27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6:26</u> , 19 <u>67</u> and that death occurred at <u>6:27</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>Shoem</u>		22b. DATE SIGNED <u>6.29.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S KRECH JR</u>		22d. ADDRESS <u>EASTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>JUNE 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST GEORGES</u>	23d. LOCATION (City or Town) (County) (State) <u>ST. GEORGES N. CASTLE DEL</u>
24. FUNERAL DIRECTOR <u>Ellen Park</u>		25a. REC'D BY REGISTRAR <u>Easton MD</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 30 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

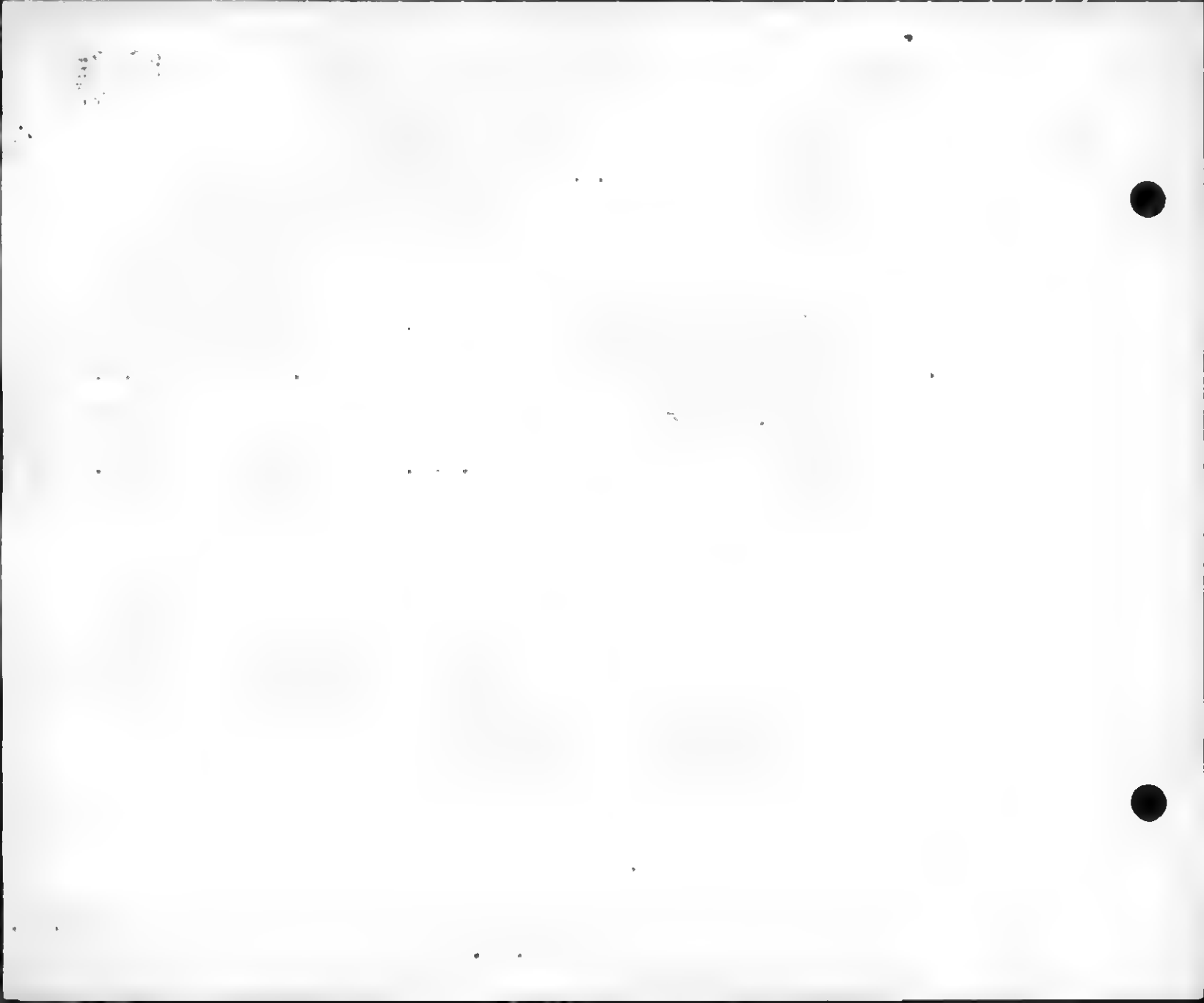
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08724

08722

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 723 Highlett Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rodney George Todd				4. DATE OF DEATH Month Day Year June 28, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1890	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Elliott, Dor. County		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laundry salesman, driver				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George W. Todd				14. MOTHER'S MAIDEN NAME Della			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. H. T. Slaughter, Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH Immed.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis S. Welty EXAMINER'S NAME (Type) louis s. welty				M.D. for CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED 6-28-67							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery, East New Market, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Kenneth R. Thomas		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE JUL 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

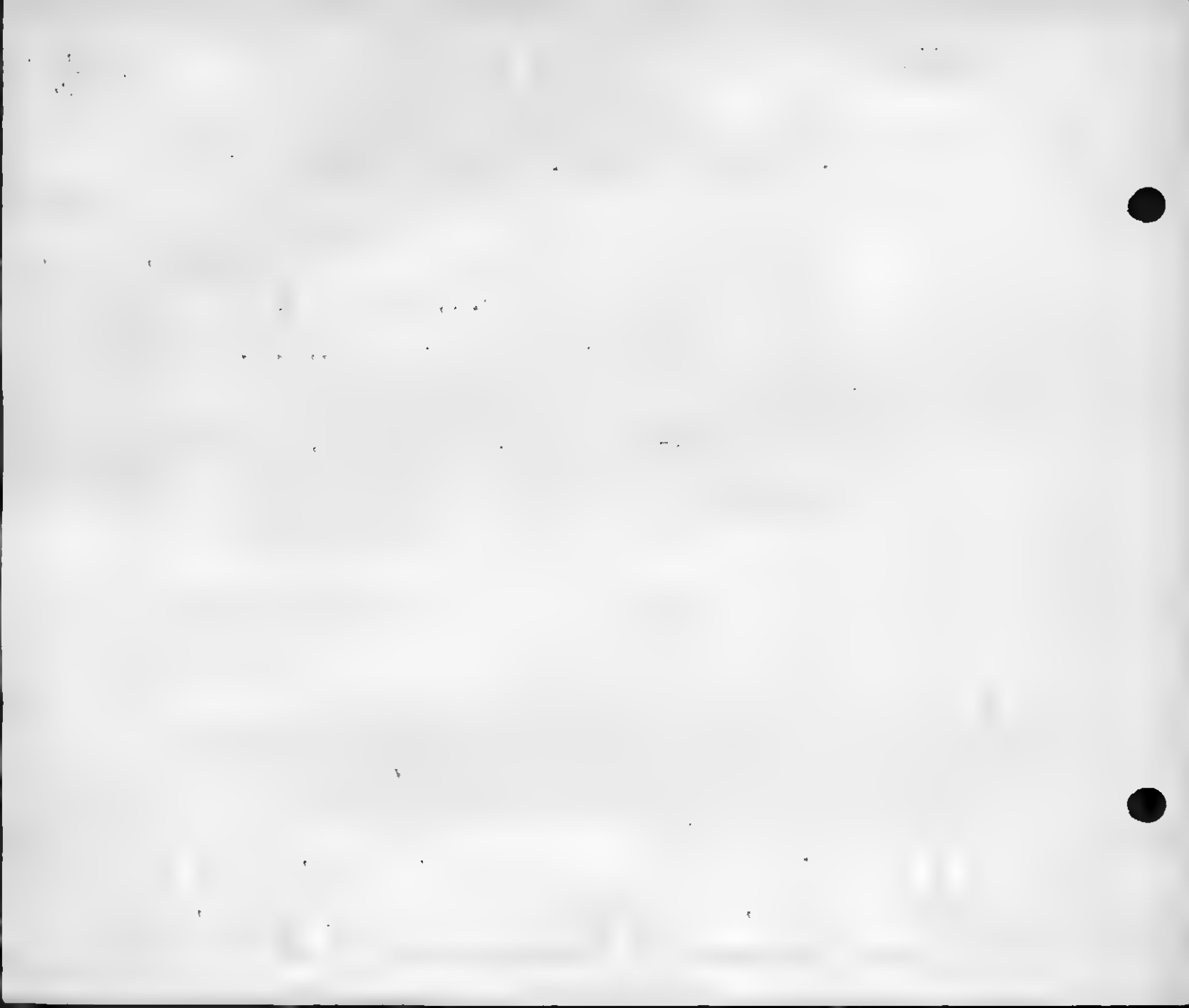
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08725

CERTIFICATE OF DEATH

08723

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels		c. LENGTH OF STAY IN lb 10 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N. J.		b. COUNTY GLOUCESTER		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLASSBORO, N. J.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rio Vista Nursing Home		3. NAME OF DECEASED (Type or print) BURRIS TURNER TOMLIN		4. DATE OF DEATH Month June Day 19 Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1881		9. AGE (in years last birthday) 85 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Gloucester Co., N. J.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Tomlin		14. MOTHER'S MAIDEN NAME Axey Stanger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 183-09=8596					
17. INFORMANT Mrs. Elsie Hamilton, Wittman, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cerebral Vascular Disease DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Prostatic Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Hypertrophy		19. INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 17, 1966 to June 19, 1967 , that (I) (we) last saw the deceased alive on June 17, 1967 , and that death occurred 3:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE R. Lane Wroth		22b. DATE SIGNED 6-19-67		22c. PHYSICIAN'S NAME (Type) R. LANE WROTH		22d. ADDRESS St. Michaels, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Beglington Cemetery		23d. LOCATION (City, town or county) Clarksboro, New Jersey			
24. FUNERAL DIRECTOR'S SIGNATURE Harrison E. Leonard, St. Michaels, Md.		25a. REC'D BY REGISTRAR JUN 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OF REGISTRATION		25d. REGISTRAR'S NAME		25e. REGISTRAR'S ADDRESS		25f. REGISTRAR'S PHONE		25g. REGISTRAR'S FAX		25h. REGISTRAR'S TELETYPE			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

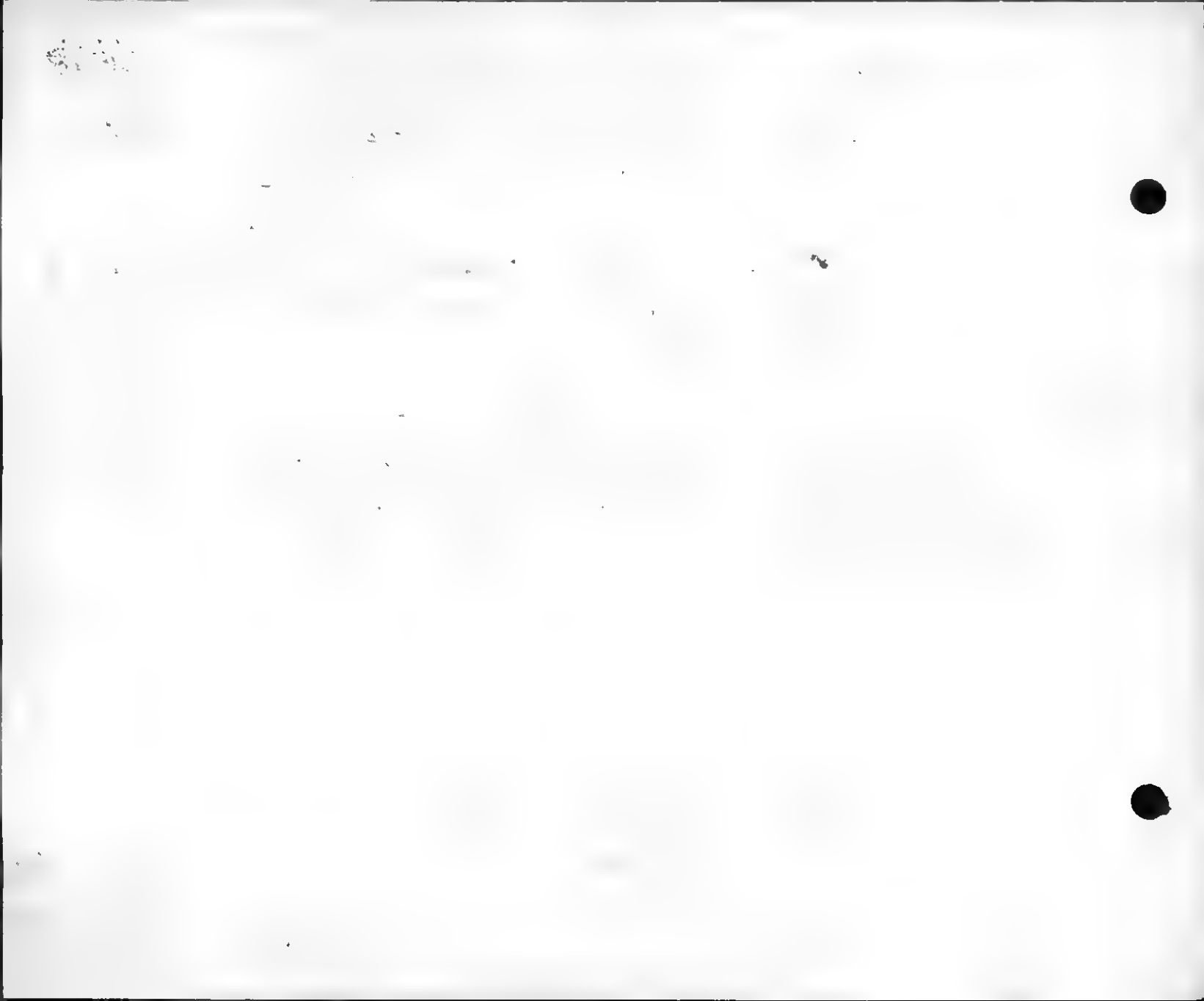
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08724

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>D.C.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXFORD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>J.</u> Last <u>Trimble</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1890</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u>4</u> Days	IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC School</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HENRY DYER</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR BARKS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-01-6399</u>		17. INFORMANT <u>MARY HALL - OXFORD, MD.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lam. Welch</u> EXAMINER'S NAME (Type) <u>WELCH</u>		M.D. <u>MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <u>6-12-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-17-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City or town) (County) (State) <u>OXFORD TALBOT MD</u>	
24. FUNERAL DIRECTOR <u>Washell Funeral Home</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

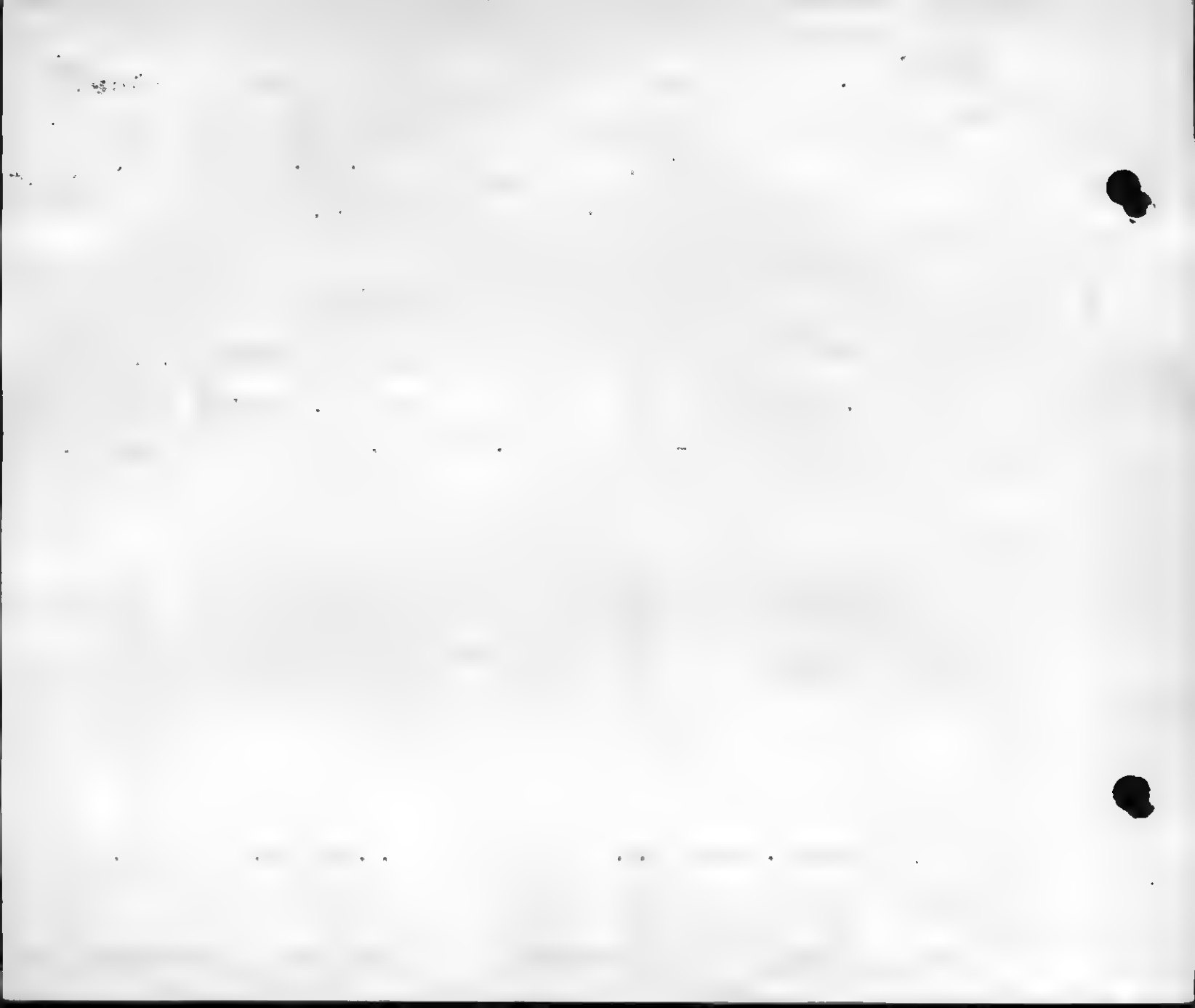
CERTIFICATE OF DEATH

08727

08725

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN It 8-MO. 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOUSE IN THE PINES, EASTON, MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE, MD. d. STREET ADDRESS 109 Mill St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James W. Waddell				4. DATE OF DEATH Month 6 Day 19 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25 Sep 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dorchester, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James W. Waddell				14. MOTHER'S MAIDEN NAME Nannie C. Manning			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 220-34-9985			
17. INFORMANT Miss Nannie B. Waddell				Address Cambridge Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration and asphyxiation DUE TO 3 2/4X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Progressive cerebral arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 12 hrs Several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1966 to June 19, 1967 that (I) (we) last saw the deceased alive on June 19, 1967 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Stephen P. Carney				22b. DATE SIGNED 6-20-67			
22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22d. ADDRESS P.O. Box 929, Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 June '67		23c. NAME OF CEMETERY OR CREMATORY Christ Churchyard		23d. LOCATION (City, town or county) (State) Cambridge Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Shaw				25a. REC'D BY REGISTRAR Charles Judge			
ADDRESS Cambridge Md.				DATE JUN 26 1967			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

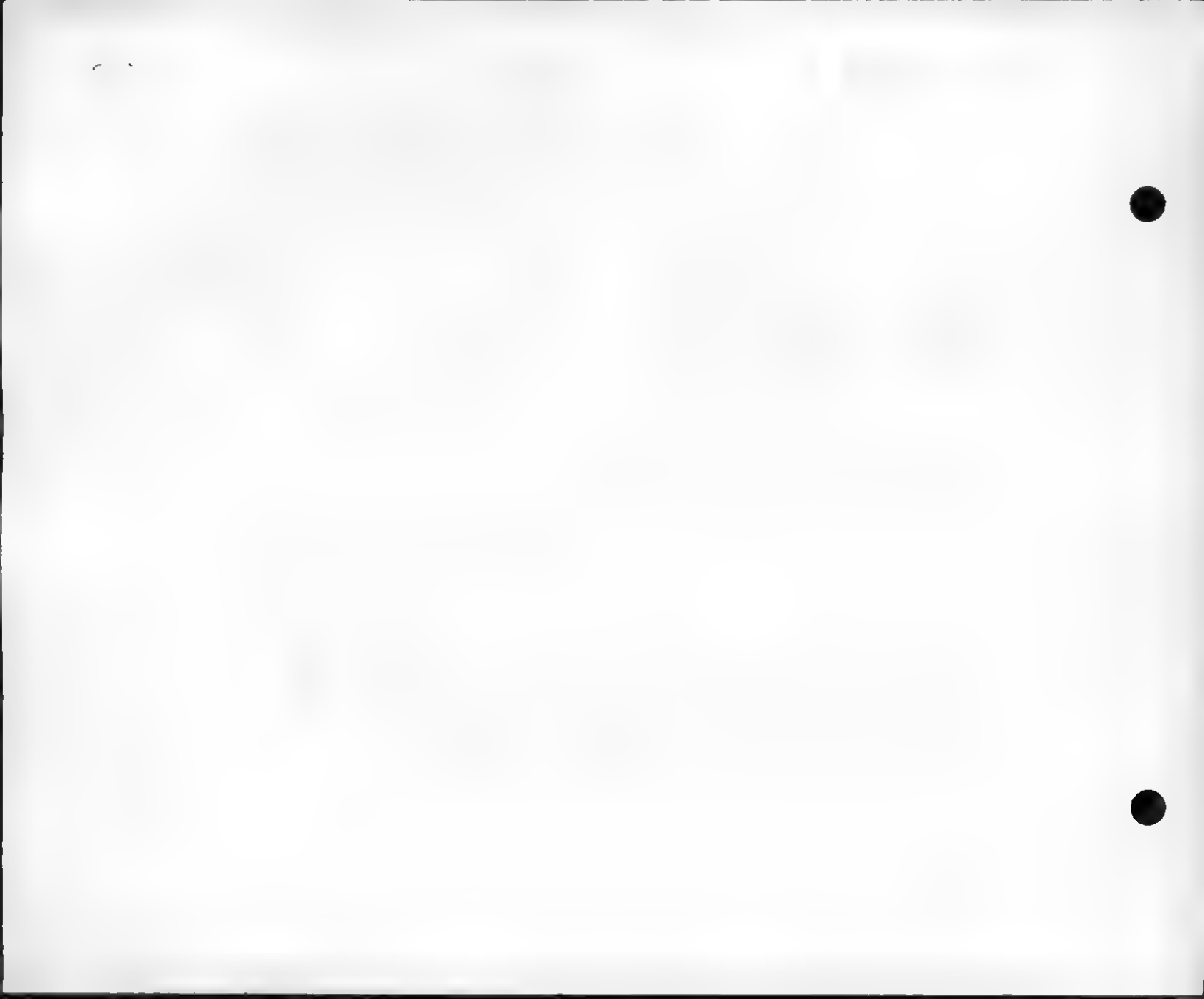
08728

08728

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROYAL OAK		c. LENGTH OF STAY IN 15 LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROYAL OAK - OWA HOME		d. STREET ADDRESS ROYAL OAK	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER SCOTT WALLACE		4 DATE OF DEATH Month Day Year JUNE 21 1967	
5 SEX MALE	6. COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-21-1895
9 AGE (In years last birthday) 72 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11 BIRTHPLACE (County & State, or foreign country) TALBOT MD.		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME WALTER SCOTT WALLACE, SR.		14. MOTHER'S MAIDEN NAME CARRIE GILSON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO 218-142737	
17 INFORMANT Maggie Howell		Address Longfellow	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing of heart & lung from Origin Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour : m p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 15 April, 1967, to 6-21, 1967 , that (I) (we) last saw the deceased alive on 6-20, 1967 , and that death occurred at 12:00 PM , from causes and on the date stated above.			
22a SIGNATURE R. Hume Watts		22b DATE SIGNED 6-20-67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 6-25-67	23c NAME OF CEMETERY OR CREMATORY ROYAL OAK	23d LOCATION (City or Town) (County) (State) ROYAL OAK TALBOT MD.
24. FUNERAL DIRECTOR A. H. Dashiell		25a. REC'D BY REGISTRAR JUN 29 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Expired 8:45 p.m. 08729

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08727

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASHINGTON,</u> b. COUNTY <u>D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>5701 SHERRIFF ROAD, N. E.</u>	
3. NAME OF DECEASED (Type or print) First <u>FORREST</u> Middle <u>B</u> Last <u>WATTS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>CR</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-46</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES P. WATTS</u>		14. MOTHER'S MAIDEN NAME <u>GALE PEAKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>DR. JOSEPH BARR</u>		Address <u>5701 SHERRIFF ROAD, N. E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture cervical spine</u> <u>8254</u> DUE TO (b) <u>Auto accident</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> p.m. <u>6-10</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Shoring</u>		20f. (City or town) (County) (State) <u>W. Easton Talbot MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Merty</u> EXAMINER'S NAME (Type)		22. DATE SIGNED <u>6-10-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>6-14-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MEMORIAL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGE CO., MARYLAND</u>	
24. FUNERAL DIRECTOR <u>JOHN T. RHINES FUNERAL HOME</u>		25a. JUDICIAL REGISTRAR <u>3015 12TH STREET, WASHINGTON, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>15 1967</u>	

CHITKA

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

3 **41**

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08730

CERTIFICATE OF DEATH

08728

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>201</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>E.</u> Last <u>Whitley</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1883</u>
9. AGE (In years birthday yrs.) <u>84</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Whitley</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Towers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unkn.</u>	
17. INFORMANT <u>Mrs. Margaret Affayroux, Baltimore, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterioneurosclerosis</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>> 1 month</u> <u>Uncertain</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>3:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>6/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS <u>M.D. Aston, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/21/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Windy Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Trappe, Md.</u>
24. FUNERAL DIRECTOR <u>Maurice E. Deeman & Son Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

86700

86700

Subject

Language

(Date) Year

*

()

1. 2. 3. 4. 5.

100

Language

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100